COSMOS
Navigate the Compliance Universe

Report on Medicare Compliance Volume 29, Number 33. September 21, 2020

Two Rules: IPPS Makes DRG Changes, OPPS Would Relax Supervision

By Nina Youngstrom

When the 2021 inpatient prospective payment system (IPPS) regulation[1] takes effect in 10 days, there will be a new case mix index (CMI) and geometric mean length of stay (GMLOS) for every MS-DRG, and they will have a ripple effect on hospitals' benchmarking data for their CMI goals. For example, the CMI for ischemic stroke with major complications and comorbidities (MCC) is going from 2.79 to 2.88, but the GMLOS is dropping from 4.8 to 4.7, which means Medicare will pay more for treating it, but hospitals will need to be a bit more efficient caring for those patients to remain below the mean length of stay. With major small and large bowel procedures with MCC, both the CMI and the GMLOS are going down.

"Every CFO wants to know what their hospital CMI is, and they're probably budgeted from a CMI goal for the year," said Ronald Hirsch, M.D., vice president of R1 RCM, at a Sept. 15 webinar sponsored by RACmonitor.com.[2] "Case managers are often held accountable for their numbers, and if the goal is to have a length of stay equal to or less than the GMLOS for their overall admissions, you have to be aware that on Oct. 1, the overall GMLOS goal is going to change." It's because CMS moved the target. "Shoot for a new goal," he said.

That's one thing worth noting in the 2021 final IPPS rule, which CMS announced Sept. 2. CMS gave hospitals only 30 days from the effective date of the IPPS final rule to incorporate it, a truncated timeline attributed to the COVID-19 pandemic. Hirsch also discussed the proposed OPPS rule,[3] which was published in the Aug. 12 *Federal Register*.[4] When it's finalized, hospitals also will have only 30 days to absorb it.

No More Faxing Without a Waiver

Speaking of the GMLOS, CMS in the final rule added the new MS-DRGs established for hip fractures to the list of MS-DRGs subject to the post-acute care transfer (PACT) payment policy. Under the PACT policy, acute-care hospital patients who get post-acute care are considered transfers, not discharges, and hospitals are paid per diems instead of MS-DRGs up to the full amount of the MS-DRG. Post-acute care includes home health within three days of discharge and same-day admission to a skilled nursing facility. The HHS Office of Inspector General in an August report[5] identified $267 million of overpayments for noncompliance with the PACT policy in connection with home health care. Even when hospitals fail to put the home health discharge disposition code on claims or misuse condition codes 42 and 43, which bypass the PACT policy, they may not collect an extra dime. For the most part, payments are only affected if the length of stay is less than the GMLOS, experts say.

In a little-noticed provision, Hirsch said the IPPS regulation requires hospitals to send medical records electronically to quality improvement organizations (QIOs) within 14 days. That may be fine for reviews of short stays and higher-weighted DRGs and other QIO reviews, but it's unrealistic when patients appeal their hospital discharges while they're still in a bed, he said. Time is of the essence, and the fax machine is indispensable for that purpose. QIOs will pay hospitals $3 per chart when they send records electronically (e.g., through esMD). Small hospitals that are unable to send electronically can get a waiver and will be paid per page to fax or mail. "But if you don't send records electronically and don't have a waiver, you don't get paid," Hirsch said. Then

again, perhaps hospitals have never been compensated by QIOs for medical records. If that's the case, they should start invoicing now.

Medicare established new MS-DRGs in the 2021 IPPS. There are DRGs for Chimeric Antigen Receptor (CAR) T-cell immunotherapy (018), kidney/pancreas transplant with dialysis (019) and kidney transplant with dialysis (650-651). CMS also moved hip fractures with hip replacement into their own DRGs (521-522) from the DRGs for joint replacement (469-470). "This is big news because the hip fractures were really screwing with bundled payments for hip replacement," Hirsch said. Patients coming in electively are very different from patients who slip on the ice and break their hip.